Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Southeast Health Services P.O. Box 170336 Dallas, TX 75217	MFDR Tracking #: M4-05-4823-01 DW Injured Da
Respondent Name and Box #: Dallas ISD Rep. Box #: 42	Emplc Insurance

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMEI

Requestor's Position Summary as stated on the Table of Disputed Services: "CPT Code was denied as "Global," however, there is no indication in the Texas Medical Fee guidelines that this charge is considered global to any other procedure performed on this date of service. Code 99212 as [sic] been down coded to 99211... Codes 97530 and 97018 were denied as "exceeds max per day," however, as of August 1, 2003, this rule no longer applies, please reprocess these procedures for payment... codes 97110 and 97018 were denied as "Global," however; there is no indication in the Texas Medical Fee Guidelines that this charge is considered global to any other procedure performed on this date of service... Code 99213 was denied as "not documented," however, the documentation attached should be sufficient to necessitate the procedure code used... This date of service was denied as "not documented," however, proper paperwork has been attached to necessitate the charges billed....."

Principle Documentation:

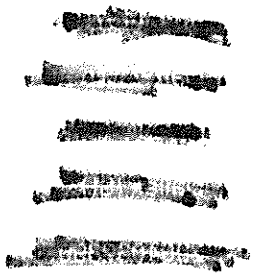
1. DWC 60 package
2. Total Amount Sought - $580.91
3. CMS 1500s
4. EOBs
5. SOAP notes
6.

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "Provider is disputing procedure code 97018 for paraffin bath, no add'l allowance is recommended. This code was global to procedure code 97035 (ultrasound) per the medical CCI edits. For procedure code 99212 (evaluation and management), these services were denied as the documentation did not meet the level of service billed. On the second submission this provider billed with a lower code. 99211. Due to the fact that the medical records were not enclosed, we are unable to comment rather or not this was justifiable. It should be noted this was only a finger injury and evaluation and management code was billed for each date of service even for those dates where treatment was on consecutive days... code 97110 for exercises was billed for 30 minutes. Previous recommendation was for 15 minutes. Again, no medical records. Documentation does not meet the level of service billed – no medical records..."

Principle Documentation:

1. Response to DWC 60



PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Reasons	Part V Reference	Amount Ordered
03/11/04, 03/12/04, 03/15/04, 03/16/04, 03/17/04, 03/18/04, 03/19/04, 03/22/04, 03/23/04, 03/24/04, 03/25/04, 03/29/04, 03/30/04, 04/13/04, 04/19/04, 04/22/04, 04/27/04, 04/29/04, 05/04/04, 05/06/04, 05/10/04, 05/13/04, 05/24/04, 06/01/04, 06/05/04	CPT Code 97018 ($7.01 x 125% = $8.76 x 25)	G2, Y1, D91, F72, N75, 01, N72, N11	1, 2, 11	$219.00
04/05/04, 04/06/04, 04/08/04, 05/03/04,	CPT Code 97018	F72, D91, G2, N11	1, 3	$ 0.00
03/12/04, 03/25/04,	CPT Code 99211	No EOB, N11	1, 4	$ 0.00
03/25/04	CPT Code 97035	F2, 01	1, 5	$ 0.00
04/06/04	CPT Code 97530	F72, D91	1, 6	$ 0.00
04/19/04	CPT Code 97110	G2, D91, F72	1, 7	$ 0.00
04/22/04, 05/17/04	CPT Code 99213 ($54.59 x 125% = $68.24 x 2 = $136.48 – 55.72)	N11	1, 8, 11	$ 80.76
05/04/04, 05/06/04, 05/13/04	CPT Code 97140-59 ($27.30 x 125% = $34.13 x 3)	N72, D91, N11	1, 9, 11	$102.39
05/20/04	CPT Code 99080-73	EOB showing payment	10	$ 0.00
Total:				$402.15

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.202, titled *Medical Fee Guideline* effective for professional medical services on or after August 1, 2003, set out the reimbursement guidelines.

1. These services were denied by the Respondent with reason code "G2 – Unbundling (included in global)"; "Y1 – Treatments exceed the MFG payment policies including the CMS medical review payment policies"; "D91 – Duplicate Bill"; "01 Denial after reconsideration. Upon review of your rerquet for reconsideration, no additional benefit is recommended"; "F2 – Fee Guideline MAR reduction. Charges exceeds the schedule maximum allowance per the Medicare Fee Guidelines"; "N11 – Not appropriate documented. Upon review, documentation as submitted does not support the level or service(s) billed. Reimbursement based on level of service documented"; "F72 – Charge exceeds the schedule maximum allowance per the Medicare Fee Guidelines"; "F72 – Fee Guideline MAR reduction. Treatment has exceeded Medicare Guidelines for length of treatment session(s)"; "N75 – Not appropriate documented. Documentation as submitted does not support the therapy modalities/procedures as billed"; "N72 – Not appropriate documented. Documentation must include treatment provided (with days of week), response to treatment, progressive overall improvement of symptoms; failure to respond to treatment should reflect a change of the treatment plan."
2. CPT Code 97018 for dates of service 03/11/04 through 06/05/04. According to 28 Texas Administrative Code Section (TAC) 134.202(b) CPT Code 97018 is considered to be the most extensive procedure when billed with code 97035. The Respondent incorrectly denied this service and reimbursement per 28 TAC Section 134.202(c)(1) is recommended.
3. CPT Code 97018 for dates of service 04/05/04, 04/06/04, 04/08/04, and 05/03/04is considered to be a component procedure of the code 97140. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be considered justifiable if a modifier is used appropriately. The Requestor did not attach a modifier; therefore, reimbursement is not recommended.

4. CPT Code 99211 for dates of service 03/12/04 and 03/25/04. According to the EOBs and CMS-1500's submitted the Requestor initially billed CPT Code 99212 and on the request for reconsideration down-coded to CPT Code 99211. Per 28 TAC Section 133.304(k)(1)(B), a copy of the complete medical bill that the health care provider is requesting the insurance carrier to reconsider must contain the identical codes and charges that are on the original medical bill. Review of the submitted EOBs document that the insurance carrier processed CPT Code 99212; therefore, this CPT Code cannot be reviewed as it has not been submitted for reconsideration.
5. CPT Code 97035 for date of service 03/25/04 denied as F2. Although the submitted EOB shows that payment, in the amount of $15.84 was made for this code, according to 28 TAC Section 134.202(b) this code is considered to be included with CPT Code 97018. A modifier is allowed in order to differentiate between the services provided and separate payment for the services billed may be considered justifiable if a modifier is used appropriately. CPT Code 97018 is defined as the most extensive procedure; therefore, Code 97035 requires a modifier. A modifier was not attached; therefore, reimbursement is not recommended.
6. CPT Code 97530 for date of service 04/06/04 denied as "F72 – Charge exceeds the schedule maximum allowance per the Medicare Fee Guideline." According to 28 TAC Section 134.202(d) a health care provider can bill their usual and customary; however, if the code is valued the provider will be reimbursed the maximum allowance. According to 28 TAC Section 134.202(b) this code is a mutually exclusive procedure of code 97140 billed on the same day. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be considered justifiable if a modifier is used appropriately. The Requestor did not append a modifier; therefore, reimbursement is not recommended.
7. CPT Code 97110 for date of service 04/19/07 denied as "G2." According to 28 TAC Section 134.202(b) CPT Code 97110 is mutually exclusive to code 97150 billed on the same day. Payment is justified if a modifier is used correctly. The Requestor did not append a modifier; therefore, reimbursement is not recommended.
8. CPT Code 99213 for date of service 04/22/04 and 05/17/04 denied as "N11." According to the CPT descriptor the evaluation and management of an established patient requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Review of the submitted SOAP notes supports the level of service billed. Therefore, per 28 TAC Section 134.202(c)(1), additional reimbursement is recommended.
9. CPT Code 97140-59 for dates of service 05/04/04, 05/06/04, 05/13/04 was denied as not being documented. Review of the SOAP notes supports the services were rendered as billed. Therefore, per 28 TAC Section 134.202(c)(1) reimbursement is recommended.
10. CPT Code 99080-73 for date of service 05/20/04. Review of the submitted EOBs reveals this code has been paid. The Requestor has documented this in the Table of Disputed Services, Total Amount Paid column which shows an amount of $15.00 as being paid. Therefore, reimbursement cannot be recommended.
11. Per review of Box 32 on CMS-1500, zip code 75217 is located in Dallas County. The maximum reimbursement amount, under Rule 134.202(b), is determined by locality.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

- Texas Labor Code Section. 413.011(a-d);
- Texas Labor Code Section. 413.031;
- Texas Labor Code Section. 413.0311;
- 28 Texas Administrative Code Section. 133.304;
- 28 Texas Administrative Code Section. 134.1;
- 28 Texas Administrative Code, Section. 134.202; and
- Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION AND/OR ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to additional reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $402.15 plus applicable accrued interest per Division Rule 134.803, due within 30 days of receipt of this Order.

ORDER:

Authorized Signature	Marguerite Soeter Auditor III Medical Fee Dispute Resolution	July 30, 2008 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.